FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005165

Facility Name: St Paul's House & Health Care Center

Address: 3831 N. Mozart Street (Number) Chicago (City) 60618 (Zip Code)

County: Cook

Telephone Number: (773) 478-4222 **Fax #** (773) 478-4516

IDPA ID Number: 36-2167897

Date of Initial License for Current Owners: 01/10/24

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Lawrence D. Carlson

(Title) Executive Director

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) Donald Magnuson

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	141	Skilled (SNF)	141	51,606	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	64	Sheltered Care (SC)	64	23,424	5
6		ICF/DD 16 or Less			6
7	205	TOTALS	205	75,030	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,969	6,499	4,408	15,876	8
9	SNF/PED					9
10	ICF	12,991	17,867		30,858	10
11	ICF/DD					11
12	SC	67		17,485	17,552	12
13	DD 16 OR LESS					13
14	TOTALS	18,027	24,366	21,893	64,286	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.68%

D. How many bed-hold days during this year were paid by Public Aid? 52 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/28/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 4,408

Medicare Intermediary AdminaStar Illinois

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/00 Fiscal Year: 06/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	293,587	58,593	168,868	521,048		521,048		521,048			1
2	Food Purchase		286,440		286,440	(35,685)	250,755		250,755			2
3	Housekeeping	101,872	33,797	183,437	319,106		319,106		319,106			3
4	Laundry	58,950	19,796		78,746		78,746		78,746			4
5	Heat and Other Utilities			222,939	222,939		222,939		222,939			5
6	Maintenance	167,519	41,229	185,245	393,993		393,993	(113,533)	280,460			6
7	Other (specify):*											7
8	**TOTAL General Services**	621,928	439,855	760,489	1,822,272	(35,685)	1,786,587	(113,533)	1,673,054			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	1,953,563	259,641	131,610	2,344,814		2,344,814		2,344,814			10
10a	Therapy			4,774	4,774		4,774		4,774			10a
11	Activities	113,871	7,904	98	121,873		121,873		121,873			11
12	Social Services	153,899	10,056	4,508	168,463		168,463		168,463			12
13	Nurse Aide Training											13
14	Program Transportation			383	383		383		383			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,221,333	277,601	146,373	2,645,307		2,645,307		2,645,307			16
	C. General Administration											
17	Administrative	142,511			142,511		142,511		142,511			17
18	Directors Fees											18
19	Professional Services			102,279	102,279		102,279	(3,569)	98,710			19
20	Dues, Fees, Subscriptions & Promotions			122,698	122,698		122,698	(47,058)	75,640			20
21	Clerical & General Office Expenses	306,494	47,185	261,351	615,030		615,030	(180,051)	434,979			21
22	Employee Benefits & Payroll Taxes			552,969	552,969	35,685	588,654	(8,413)	580,241			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,883	15,883		15,883		15,883			24
25	Other Admin. Staff Transportation			1,612	1,612		1,612		1,612			25
26	Insurance-Prop.Liab.Malpractice			44,621	44,621		44,621		44,621			26
27	Other (specify):*											27
28	**TOTAL General Administration**	449,005	47,185	1,101,413	1,597,603	35,685	1,633,288	(239,091)	1,394,197			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,292,266	764,641	2,008,275	6,065,182		6,065,182	(352,624)	5,712,558			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

St Paul's House & Health Care Center **0005165**

COST REPORT RECLASSIFICATIONS

07/01/99

06/30/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	35,685	
2	FOOD		35,685

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number St Paul's House & Health Care Center #0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			490,521	490,521		490,521	92,195	582,716			30
31	Amortization of Pre-Op. & Org.			13,008	13,008		13,008		13,008			31
32	Interest			362,489	362,489		362,489	(87,323)	275,166			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			34,014	34,014		34,014		34,014			35
36	Other (specify):*											36
37	**TOTAL Ownership**			900,032	900,032		900,032	4,872	904,904			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		390,810	346,991	737,801		737,801		737,801			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,200	77,200		77,200		77,200			42
43	Other (specify):*	97,017			97,017		97,017	(97,017)				43
44	**TOTAL Special Cost Centers**	97,017	390,810	424,191	912,018		912,018	(97,017)	815,001			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,389,283	1,155,451	3,332,498	7,877,232		7,877,232	(444,769)	7,432,463			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,413)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	92,195	30		9
10	Interest and Other Investment Income	(2,330)	32		10
11	Discounts, Allowances, Rebates & Refunds	(203)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(179,848)	21		24
25	Fund Raising, Advertising and Promotional	(47,058)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(369,192)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (514,849)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	70,080		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 70,080		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (444,769)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Paul's House & Health Care Center

ID# 0005165

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Marketing Salaries	(97,017)	43	2
3	Fundraising Expenses	(155,073)	43	3
4	Prior Period Legal Fees	(3,569)	19	4
5	Capitalized Repair/Maintenance	(113,533)	6	5
6				6
7				7
8				8
9				9
10				10
11				11
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85				85
86				86
87				87
88				88
89				89
90	**Total**	(369,192)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(113,533)	0	0	0	0	0	0	0	0	0	0	(113,533)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(113,533)	0	0	0	0	0	0	0	0	0	0	(113,533)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,569)	0	0	0	0	0	0	0	0	0	0	(3,569)	19
20	Fees, Subscriptions & Promotions	(47,058)	0	0	0	0	0	0	0	0	0	0	(47,058)	20
21	Clerical & General Office Expenses	(180,051)	0	0	0	0	0	0	0	0	0	0	(180,051)	21
22	Employee Benefits & Payroll Taxes	(8,413)	0	0	0	0	0	0	0	0	0	0	(8,413)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(239,091)	0	0	0	0	0	0	0	0	0	0	(239,091)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(352,624)	0	0	0	0	0	0	0	0	0	0	(352,624)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	92,195	0	0	0	0	0	0	0	0	0	0	92,195	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,330)	(84,993)	0	0	0	0	0	0	0	0	0	(87,323)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	89,865	(84,993)	0	0	0	0	0	0	0	0	0	4,872	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(252,090)	155,073	0	0	0	0	0	0	0	0	0	(97,017)	43
44	**TOTAL Special Cost Centers**	(252,090)	155,073	0	0	0	0	0	0	0	0	0	(97,017)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(514,849)	70,080	0	0	0	0	0	0	0	0	0	(444,769)	45

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				St. Pauls House Foundation	Chicago	Fund Raising

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Investment Management Fees	$	St. Pauls Foundation	100.00%	$ 29,519	$ 29,519	1
2	V	32	Investment Income	114,512	St. Pauls Foundation	100.00%		(114,512)	2
3	V	43	Fundraising Expense		St. Pauls Foundation	100.00%	155,073	155,073	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 114,512			$ 184,592	$ * 70,080	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bond Debenture		X	Source of Funds	None	06/96	$ 6,500,000	$ 6,164,600	2/1/2025	Variable	$ 235,874	1
2	Debenture Bonds Payable		X	Source of Funds	None	Various	70,800	17,700	Various	7.0000	2,230	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle National Bank	X		Working Capital	Interest Only		500,000	500,000	12/1/98	9.5000	45,136	6
7												7
8												8
9	TOTAL Facility Related						$ 7,070,800	$ 6,682,300			$ 283,241	9
	B. Non-Facility Related*											
10	Supplemental Schedule										79,249	10
11	St. Paul Foundation Interest										29,519	11
12	St. Paul Foundation Interest										(114,512)	12
13	Interest Income										(2,330)	13
14	TOTAL Non-Facility Related						$	$			$ (8,074)	14
15	TOTALS (line 9+line14)						$ 7,070,800	$ 6,682,300			$ 275,167	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Commission on Line of Credit		X	Working Capital			$	$			$ 64,624	1
2	William Blair										8,125	2
3	Northwest Bank S/P										6,500	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 79,249	21

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	N/A	8
1996	N/A	9
1997	N/A	10
1998	N/A	11
1999	N/A	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,138 B. General Construction Type: Exterior Brick Frame N/A Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

St. Pauls Residence - 2815 W. Baron, Chicago, IL 60618

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 359,737
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 13,008
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1910	$ 103,080	1
2					2
3	TOTALS			$ 103,080	3

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	205		1974	1974	$ 1,284,322	$ 25,721	35	$ 42,811	$ 17,090	$ 712,172	4
5			1949	1949	332,671		35			328,168	5
6			1980	1980	3,941						6
7			1986	1986	3,871,467	129,049	35	193,573	64,524	2,258,353	7
8											8
	Improvement Type**										
9	Various			1949	4,028		20			3,677	9
10	Various			1950	18,779	57	20		(57)	18,576	10
11	Various			1951	854	1	20		(1)	751	11
12	Various			1954	2,310		20			2,310	12
13	Various			1956	78,061	1,561	20		(1,561)	60,105	13
14	Various			1972	2,363		20			2,363	14
15	Various			1974	4,970		20			4,970	15
16	Various			1975	2,390		20			2,390	16
17	Various			1976	27,003		20				17
18	Various			1977	3,525		20			3,525	18
19	Various			1978	533,315		20			535,956	19
20	Various			1979	98,663		20			98,663	20
21	Various			1980	278		20			278	21
22	Various			1981	77,792	3,721	20	3,721		75,932	22
23	Various			1982	88,065	254	20	1,781	1,527	87,750	23
24	Various			1984	21,915		20			21,915	24
25	Various			1985	235,600	6,654	20	10,600	3,946	200,699	25
26	Various			1986	99,966	1,874	20	2,788	914	71,804	26
27	Various			1987	17,045	175	20	711	536	5,987	27
28	Various			1988	1,500		20			1,500	28
29	Various			1989	5,140		20			5,140	29
30	Various			1990	58,255	2,913	20	2,913		30,586	30
31	Various			1992	47,328	88	20	2,366	2,278	3,158	31
32	PAGE 12D TOTALS				103,957	1,240		2,001	761	2,001	32
33	PAGE 12C TOTALS				71,440	3,314		4,268	954	5,367	33
34	PAGE 12B TOTALS				134,753	7,436		9,029	1,593	13,740	34
35	PAGE 12A TOTALS				6,297,212	227,613		221,152	(6,461)	816,788	35
36	TOTAL (lines 4 thru 35)				$ 13,528,908	$ 411,671		$ 497,714	$ 86,043	$ 5,374,624	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	8,500	340	20	425	85	3,145	9
10	Various			1994	6,104		20	611	611	3,972	10
11	Various			1995	17,542	584	20	878	294	4,829	11
12	CAPITALIZED INTEREST			1996		8,136	20		(8,136)		12
13	ROOF			1996	57,995	2,900	20	2,900		13,050	13
14	WATER TREATMENT EQUI			1996	4,654		20	233	233	1,049	14
15	CIP - LEASEHOLD IMP			1996	183,297	9,165	20	9,165		33,605	15
16	CAPL INTEREST INCOME			1996		(2,715)	20		2,715		16
17	BUILDING HOLD			1996	5,828,604	197,077	20	194,287	(2,790)	723,970	17
18	LAND IMPROVEMENT			1997	1,343	67	20	67		195	18
19	ENGINEERING FEES			1997	18,967	948	20	948		2,844	19
20	BLINDS			1997	2,068	207	20	207		587	20
21	MACHINERY			1997	7,940	1,588	20	1,588		5,161	21
22	ELECTION CAMPAIGN			1997	4,350	218	20	218		654	22
23	CENTIMARK			1997	83,622	4,181	20	4,181		11,149	23
24	ARCHITECTS-95 RENOV			1997	31,626	1,054	20	1,581	527	4,480	24
25	GAS REGULATORS			1997	7,984	399	20	399		1,097	25
26	SEAL KITS & PUMP			1998	1,140	57	20	57		105	26
27	LIGHT FIXTURES			1998	1,683	84	20	84		189	27
28	ACCESS DOORS			1998	3,924	196	20	196		310	28
29	IU-PRO			1998	3,543	177	20	177		398	29
30	SMOKE DAMPER			1998	480	24	20	24		42	30
31	FIRE SYSTEM			1998	5,369	268	20	268		558	31
32	SECURITY SYSTEM			1998	2,245	112	20	112		261	32
33	SEWER REPAIR			1998	1,884	94	20	94		235	33
34	DUCT MEASUREMENTS			1998	119	6	20	6		11	34
35	TELEPHONE SYSTEM			1998	12,229	2,446	20	2,446		4,892	35
36	TOTAL (lines 4 thru 35)				$ 6,297,212	$ 227,613		$ 221,152	$ (6,461)	$ 816,788	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	RESTROOM SIGNAGE			1998	2,368	118	20	118		266	9
10	STEEL GUARDRAIL			1998	1,500	75	20	75		125	10
11	SEAL KITS & PUMPS			1998	570	29	20	29		53	11
12	STAIR RAILINGS			1998	4,255	213	20	213		373	12
13	ACCESS DOORS			1998	1,992	100	20	100		167	13
14	FIRE ALARM SYSTEM			1998	2,740	137	20	137		274	14
15	HINGES,LOCKS			1998	3,670	184	20	184		337	15
16	SEWAGE PUMP			1998	4,560	228	20	228		399	16
17	ACCESS DOORS/DAMPERS			1998	647	32	20	32		51	17
18	FIRE ALARM SERVICE			1998	2,740	137	20	137		274	18
19	TELEPHONE - DIGITAL			1998	2,770	554	20	554		970	19
20	CR ADJ CAP PAINTING			1998	24,734		20	1,237	1,237	1,237	20
21	FIRE DAMPERS			1998	2,061	103	20	103		163	21
22	TELEPHONE SYSTEM			1998	12,229	2,446	20	2,446		4,688	22
23	DOORS,HINGES			1998	3,670	184	20	184		307	23
24	DOOR CLOSURES		***	1999	7,531	251	20	251		251	24
25	CAST IRON		***	1999	800	33	20	33		33	25
26	RAILINGS		***	1999	1,766	66	20	66		66	26
27	FIREPROOFING		***	1999	4,000	200	20	200		200	27
28	PUMP MATERIALS			1999	381	19	20	19		29	28
29	SMOKE DAMPERS			1999	20,380	1,019	20	1,019		1,444	29
30	DOORS		***	1999	10,680		20	356	356	356	30
31	DRAIN COVERS		***	1999	1,216	51	20	51		51	31
32	SMOKE/FIRE DAMPERS			1999	708	35	20	35		50	32
33	PH SYSTEM, SPEAKERS			1999	4,250	850	20	850		1,204	33
34	DOOR CLOSURES		***	1999	1,460	49	20	49		49	34
35	CARPENTRY REPAIRS		***	1999	11,075	323	20	323		323	35
36	TOTAL (lines 4 thru 35)				$ 134,753	$ 7,436		$ 9,029	$ 1,593	$ 13,740	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

***Items put to use after 6/30/99

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SMOKE DAMPER CONSULT			1999	367	18	20	18		26	9
10	FIRE DAMPER ACTIVATO			1999	195	10	20	10		13	10
11	INSTALL CARPET		***	1999	780	23	20	23		23	11
12	DOOR CLOSURES		***	1999	945	27	20	27		27	12
13	DOOR CLOSURES		***	1999	1,833	61	20	61		61	13
14	PII SYSTEM, TAPE DRI			1999	6,971	1,394	20	1,394		2,091	14
15	PII SYSTEM, OFFICE 9			1999	4,251	850	20	850		1,204	15
16	BENCHES		***	1999	1,457	43	20	43		43	16
17	REPAIR		***	1999	1,200	60	20	60		60	17
18	INSPECTION DOORS			1999	1,240	62	20	62		93	18
19	INSTALL TILE		***	1999	688	20	20	20		20	19
20	INSTALL DOOR		***	1999	2,098	96	20	96		96	20
21	DRYWALL REPAIR & PNT		***	1999	11,725		20	391	391	391	21
22	DRYWALL REPAIR & PNT		***	1999	10,615		20	354	354	354	22
23	DRYWALL REPAIR & PNT		***	1999	12,298		20	359	359	359	23
24	PLASTIC LUMBER		***	1999	1,421		20	41	41	41	24
25	AIR HANDLER		***	1999	1,067		20	40	40	40	25
26	DOORS		***	1999	787		20	23	23	23	26
27	PIPING		***	1999	3,682	245	20	123	(122)	123	27
28	BOILER REPAIR		***	1999	951	55	20	28	(27)	28	28
29	DRAPERIES		***	1999	3,012	301	20	151	(150)	151	29
30	DAMPER AIR COMPRESSO		***	1999	292	15	20	15		21	30
31	INSTALL CARPET			2000	420	11	20	11		11	31
32	CARPET			2000	640		20	5	5	5	32
33	RAILINGS			2000	903	23	20	23		23	33
34	HEAT/COOL CONTROL			2000	554		20	14	14	14	34
35	SOLENOID VALVE			2000	1,048		20	26	26	26	35
36	TOTAL (lines 4 thru 35)				$ 71,440	$ 3,314		$ 4,268	$ 954	$ 5,367	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

***Items put to use after 6/30/99

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSTALL CARPET			2000	120	2	20	2		2	9
10	INSTALL CARPET			2000	120	3	20	3		3	10
11	AIR DIVERTERS & SCRN			2000	1,423		20	12	12	12	11
12	PLUM INSTALLATION			2000	7,900	66	20	33	(33)	33	12
13	ELECTRIC STARTER MOT			2000	978		20	12	12	12	13
14	ELEV REMODELING			2000	7,890	33	20	33		33	14
15	HALLWAY REPAIR			2000	6,219	26	20	26		26	15
16	FOUNDATION STUDY			2000	4,300	108	20	108		108	16
17	BOILER TUBES			2000	324	16	20	8	(8)	8	17
18	SHADES			2000	11,434	572	20	286	(286)	286	18
19	BLINDS			2000	1,514	13	20	6	(7)	6	19
20	VALVES & GRATES			2000	1,865		20	16	16	16	20
21	BOILER TUBES			2000	9,628	401	20	200	(201)	200	21
22	PAINTING/DECORATING		***	1999	9,850		20	246	246	246	22
23	PAINTING/DECORATING		***	1999	32,780		20	820	820	820	23
24	ROOFING		***	1999	7,612		20	190	190	190	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 103,957	$ 1,240		$ 2,001	$ 761	$ 2,001	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

***Items put to use after 6/30/99

FacilityID	AssetDescription	AcqYear	CostSt	YTDDeprFd	LifeSt	YTDDeprSt	AdjSt	AccumDepr
00005165	Various	1949	4028	0	20	0	0	3677
00005165	Various	1950	18779	57	20	0	-57	18576
00005165	Various	1951	854	1	20	0	-1	751
00005165	Various	1954	2310	0	20	0	0	2310
00005165	Various	1956	78061	1561	20	0	-1561	60105
00005165	Various	1972	2363	0	20	0	0	2363
00005165	Various	1974	4970	0	20	0	0	4970
00005165	Various	1975	2390	0	20	0	0	2390
00005165	Various	1976	27003	0	20	0	0	0
00005165	Various	1977	3525	0	20	0	0	3525
00005165	Various	1978	533315	0	20	0	0	535956
00005165	Various	1979	98663	0	20	0	0	98663
00005165	Various	1980	278	0	20	0	0	278
00005165	Various	1981	77792	3721	20	3721	0	75932
00005165	Various	1982	88065	254	20	1781	1527	87750
00005165	Various	1984	21915	0	20	0	0	21915
00005165	Various	1985	235600	6654	20	10600	3946	200699
00005165	Various	1986	99966	1874	20	2788	914	71804
00005165	Various	1987	17045	175	20	711	536	5987
00005165	Various	1988	1500	0	20	0	0	1500
00005165	Various	1989	5140	0	20	0	0	5140
00005165	Various	1990	58255	2913	20	2913	0	30586
00005165	Various	1992	47328	88	20	2366	2278	3158
00005165	Various	1993	8500	340	20	425	85	3145
00005165	Various	1994	6104	0	20	611	611	3972
00005165	Various	1995	17542	584	20	878	294	4829
00005165	CAPITALIZED INTEREST	1996	0	8136	20	0	-8136	0
00005165	ROOF	1996	57995	2900	20	2900	0	13050
00005165	WATER TREATMENT EQUI	1996	4654	0	20	233	233	1049
00005165	CIP - LEASEHOLD IMP	1996	183297	9165	20	9165	0	33605
00005165	CAPL INTEREST INCOME	1996	0	-2715	20	0	2715	0
00005165	BUILDING HOLD	1996	5828604	197077	20	194287	-2790	723970
00005165	LAND IMPROVEMENT	1997	1343	67	20	67	0	195
00005165	ENGINEERING FEES	1997	18967	948	20	948	0	2844
00005165	BLINDS	1997	2068	207	20	207	0	587
00005165	MACHINERY	1997	7940	1588	20	1588	0	5161
00005165	ELECTION CAMPAIGN	1997	4350	218	20	218	0	654
00005165	CENTIMARK	1997	83622	4181	20	4181	0	11149
00005165	ARCHITECTS-95 RENOV	1997	31626	1054	20	1581	527	4480
00005165	GAS REGULATORS	1997	7984	399	20	399	0	1097
00005165	SEAL KITS & PUMP	1998	1140	57	20	57	0	105
00005165	LIGHT FIXTURES	1998	1683	84	20	84	0	189
00005165	ACCESS DOORS	1998	3924	196	20	196	0	310
00005165	IU-PRO	1998	3543	177	20	177	0	398
00005165	SMOKE DAMPER	1998	480	24	20	24	0	42
00005165	FIRE SYSTEM	1998	5369	268	20	268	0	558
00005165	SECURITY SYSTEM	1998	2245	112	20	112	0	261
00005165	SEWER REPAIR	1998	1884	94	20	94	0	235
00005165	DUCT MEASUREMENTS	1998	119	6	20	6	0	11
00005165	TELEPHONE SYSTEM	1998	12229	2446	20	2446	0	4892
00005165	RESTROOM SIGNAGE	1998	2368	118	20	118	0	266
00005165	STEEL GUARDRAIL	1998	1500	75	20	75	0	125
00005165	SEAL KITS & PUMPS	1998	570	29	20	29	0	53
00005165	STAIR RAILINGS	1998	4255	213	20	213	0	373
00005165	ACCESS DOORS	1998	1992	100	20	100	0	167
00005165	FIRE ALARM SYSTEM	1998	2740	137	20	137	0	274
00005165	HINGES,LOCKS	1998	3670	184	20	184	0	337
00005165	SEWAGE PUMP	1998	4560	228	20	228	0	399
00005165	ACCESS DOORS/DAMPERS	1998	647	32	20	32	0	51
00005165	FIRE ALARM SERVICE	1998	2740	137	20	137	0	274
00005165	TELEPHONE - DIGITAL	1998	2770	554	20	554	0	970
00005165	CR ADJ CAP PAINTING	1998	24734	0	20	1237	1237	1237
00005165	FIRE DAMPERS	1998	2061	103	20	103	0	163
00005165	TELEPHONE SYSTEM	1998	12229	2446	20	2446	0	4688
00005165	DOORS,HINGES	1998	3670	184	20	184	0	307
00005165	DOOR CLOSURES	1999	7531	251	20	251	0	251
00005165	CAST IRON	1999	800	33	20	33	0	33
00005165	RAILINGS	1999	1766	66	20	66	0	66
00005165	FIREPROOFING	1999	4000	200	20	200	0	200
00005165	PUMP MATERIALS	1999	381	19	20	19	0	29
00005165	SMOKE DAMPERS	1999	20380	1019	20	1019	0	1444
00005165	DOORS	1999	10680	0	20	356	356	356
00005165	DRAIN COVERS	1999	1216	51	20	51	0	51
00005165	SMOKE/FIRE DAMPERS	1999	708	35	20	35	0	50
00005165	PH SYSTEM, SPEAKERS	1999	4250	850	20	850	0	1204
00005165	DOOR CLOSURES	1999	1460	49	20	49	0	49
00005165	CARPENTRY REPAIRS	1999	11075	323	20	323	0	323
00005165	SMOKE DAMPER CONSULT	1999	367	18	20	18	0	26
00005165	FIRE DAMPER ACTIVATO	1999	195	10	20	10	0	13
00005165	INSTALL CARPET	1999	780	23	20	23	0	23
00005165	DOOR CLOSURES	1999	945	27	20	27	0	27
00005165	DOOR CLOSURES	1999	1833	61	20	61	0	61
00005165	P11 SYSTEM, TAPE DRI	1999	6971	1394	20	1394	0	2091
00005165	P11 SYSTEM, OFFICE 9	1999	4251	850	20	850	0	1204
00005165	BENCHES	1999	1457	43	20	43	0	43
00005165	REPAIR	1999	1200	60	20	60	0	60
00005165	INSPECTION DOORS	1999	1240	62	20	62	0	93
00005165	INSTALL TILE	1999	688	20	20	20	0	20
00005165	INSTALL DOOR	1999	2098	96	20	96	0	96
00005165	DRYWALL REPAIR & PNT	1999	11725	0	20	391	391	391
00005165	DRYWALL REPAIR & PNT	1999	10615	0	20	354	354	354
00005165	DRYWALL REPAIR & PNT	1999	12298	0	20	359	359	359
00005165	PLASTIC LUMBER	1999	1421	0	20	41	41	41
00005165	AIR HANDLER	1999	1067	0	20	40	40	40
00005165	DOORS	1999	787	0	20	23	23	23
00005165	PIPING	1999	3682	245	20	123	-122	123
00005165	BOILER REPAIR	1999	951	55	20	28	-27	28
00005165	DRAPERIES	1999	3012	301	20	151	-150	151
00005165	DAMPER AIR COMPRESSO	1999	292	15	20	15	0	21
00005165	INSTALL CARPET	2000	420	11	20	11	0	11
00005165	CARPET	2000	640	0	20	5	5	5
00005165	RAILINGS	2000	903	23	20	23	0	23
00005165	HEAT/COOL CONTROL	2000	554	0	20	14	14	14
00005165	SOLENOID VALVE	2000	1048	0	20	26	26	26
00005165	INSTALL CARPET	2000	120	2	20	2	0	2
00005165	INSTALL CARPET	2000	120	3	20	3	0	3
00005165	AIR DIVERTERS & SCRN	2000	1423	0	20	12	12	12
00005165	PLUM INSTALLATION	2000	7900	66	20	33	-33	33
00005165	ELECTRIC STARTER MOT	2000	978	0	20	12	12	12
00005165	ELEV REMODELING	2000	7890	33	20	33	0	33
00005165	HALLWAY REPAIR	2000	6219	26	20	26	0	26
00005165	FOUNDATION STUDY	2000	4300	108	20	108	0	108
00005165	BOILER TUBES	2000	324	16	20	8	-8	8
00005165	SHADES	2000	11434	572	20	286	-286	286
00005165	BLINDS	2000	1514	13	20	6	-7	6
00005165	VALVES & GRATES	2000	1865	0	20	16	16	16
00005165	BOILER TUBES	2000	9628	401	20	200	-201	200

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,236,939	$ 69,693	$ 76,665	$ 6,972		$ 1,028,410	37
38	Current Year Purchases	140,981	8,229	6,001	(2,228)		6,001	38
39	Fully Depreciated Assets	607,355	928	2,336	1,408		607,355	39
40								40
41	TOTALS	$ 1,985,275	$ 78,850	$ 85,002	$ 6,152		$ 1,641,766	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Van	Van	1994	$ 37,650	$	$	$	5	$ 37,650	42
43										43
44										44
45										45
46	TOTALS			$ 37,650	$	$	$		$ 37,650	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 15,654,913	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 490,521	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 582,716	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 92,195	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 7,054,040	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	New Entrance Way	$ 108,754	58
59			59
60			60
61		$ 108,754	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

St Paul's House & Health Care Center
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
06/30/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
	1,236,939	69,693	76,665	6,972	1,028,410
TOTALS	1,236,939	69,693	76,665	6,972	1,028,410
LINE 29: CURRENT YEAR					
	140,981	8,229	6,001	(2,228)	6,001
TOTALS	140,981	8,229	6,001	(2,228)	6,001
LINE 30: FULLY DEPRECIATED					
	607,355	928	2,336	1,408	607,355
TOTALS	607,355	928	2,336	1,408	607,355

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		205		$			3
4	Additions							4
5								5
6								6
7	TOTAL		205		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 34,014 Description: PB Postage Machine-1,968, IKON/Savin Copier-$22,054, SLS G/L Sys.-$,5,760, Pref Comm Computer Sys-$4,23
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 131,857	$		$ 131,857	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,469			3,469	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			211,665			211,665	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				376,786		376,786	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): SEE SUPP SCHED	39-2				0	14,024		14,024	13
14	TOTAL			$		$ 346,991	$ 390,810		$ 737,801	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Laboratory	3,615
2	Complex Medical Equip	8,789
3	Radiology	1,620
4		
5		
6		
7		
8		
9		
10		
		14,024

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 153,558	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,483,016		3
4	Supply Inventory (priced at)	45,267		4
5	Short-Term Investments			5
6	Prepaid Insurance	128,127		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,809,968	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	103,081		13
14	Buildings, at Historical Cost	13,160,823		14
15	Leasehold Improvements, at Historical Cos	252,533		15
16	Equipment, at Historical Cost	2,158,147		16
17	Accumulated Depreciation (book methods)	(6,653,959)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	359,737		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(39,024)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	108,754		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,450,092	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,260,060	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 415,092	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	662,300		29
30	Accrued Salaries Payable	366,408		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,128		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	26,210		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,476,138	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,020,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,020,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,496,138	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,763,922	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,260,060	$	48

*(See instructions.)

Facility Name & ID Number St Paul's House & Health Care Center **#** 0005165 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 06/30/00

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Real Estate Tax Escrow			Accrued Expenses		
			Accrued R. E. Tax - Non Care Property		
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress	108,754				
Utility Deposit					
Loan Costs					
	108,754				

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,961,391	1
2	Restatements (describe):		2
3	**Schedule attached**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,961,391	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(197,469)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (197,469)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,763,922	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	St Paul's House & Health Care Cente #	0005165	Report Period Beginning:	07/01/99	Ending:	**06/30/00**

Balance per General Ledger		3,961,391
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		3,961,391
Equity(Deficit) from Page 17 Col 1		3,763,922
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		3,763,922

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,760,890	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,760,890	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	111,472	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 111,472	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	5,075	12
13	Barber and Beauty Care	1,341	13
14	Non-Patient Meals	8,061	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	292,704	17
18	Sale of Supplies to Non-Patients	104,664	18
19	Laboratory	16,746	19
20	Radiology and X-Ray		20
21	Other Medical Services	42,781	21
22	Laundry	18,511	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 489,883	23
	D. Non-Operating Revenue		
24	Contributions	313,306	24
25	Interest and Other Investment Income***	2,330	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 315,636	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,882	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,882	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,679,763	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,822,272	31
32	Health Care	2,645,307	32
33	General Administration	1,597,603	33
	B. Capital Expense		
34	Ownership	900,032	34
	C. Ancillary Expense		
35	Special Cost Centers	834,818	35
36	Provider Participation Fee	77,200	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,877,232	40
41	**Income before Income Taxes (line 30 minus line 40)****	(197,469)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (197,469)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Paul's House & Health Care Cente # 0005165 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUPPLEMENTAL SCHEDULE OF REVENUES
06/30/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	1,679
2	Purchase Discounts	203
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
	TOTALS	1,882

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,220	$ 75,014	$ 33.79	1
2	Assistant Director of Nursing	2,438	2,582	67,358	26.09	2
3	Registered Nurses	38,876	44,064	902,096	20.47	3
4	Licensed Practical Nurses	3,088	3,652	57,353	15.70	4
5	Nurse Aides & Orderlies	80,378	86,882	827,188	9.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,600	2,186	35,347	16.17	9
10	Activity Assistants	7,826	8,906	78,524	8.82	10
11	Social Service Workers	7,482	8,574	153,898	17.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,806	8,084	85,047	10.52	14
15	Cook Helpers/Assistants	27,858	29,356	208,540	7.10	15
16	Dishwashers					16
17	Maintenance Workers	15,140	16,578	167,519	10.10	17
18	Housekeepers	13,062	14,644	101,872	6.96	18
19	Laundry	7,930	8,748	58,950	6.74	19
20	Administrator	1,808	2,192	142,511	65.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,818	21,654	306,494	14.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,982	2,606	24554	9.42	31
32	Other Health Care(specify)					32
33	Other(specify)	4,856	6,200	97,017	15.65	33
34	TOTAL (lines 1 - 33)	242,900	269,128	$ 3,389,282 *	$ 12.59	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Fee	$ 168,868	1-3	35
36	Medical Director	160	5,000	9-3	36
37	Medical Records Consultant	Fee-Monthly	3,936	10-3	37
38	Nurse Consultant	Fee-Monthly	48,000	10-3	38
39	Pharmacist Consultant	Fee-Monthly	2,460	10-3	39
40	Physical Therapy Consultant	53	3,201	10a-3	40
41	Occupational Therapy Consultant	26	1,573	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Fee	98	11-3	44
45	Social Service Consultant	Fee	4,508	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	239	$ 237,644		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	386	$ 15,443		50
51	Licensed Practical Nurses	1,930	61,771		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,316	$ 77,214		53

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing Salaries	4,856	6,200	$ 97,017	$ 15.65
	4,856	6,200	$ 97,017	$ 15.65

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lawrence D. Carlson	Exec. Director	0	$ 142,511
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,511

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Frost, Ruttenberg and Rothblatt	Accounting/Billing	61,082
Katten Muchin Zavis	Legal	33,042
Automatic Data Processing	Payroll	8,155
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 102,279

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,942
Unemployment Compensation Insurance	5,325
FICA Taxes	258,437
Employee Health Insurance	124,997
Employee Meals	35,685
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	8,279
Long Term Disability	5,485
Pension	87,393
Employee Events	1,759
Employee meals-income	(8,061)
TOTAL (agree to Schedule V, line 22, col.8)	$ 580,241

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,307
Health Care Worker Background Check	
(Indicate # of checks performed 164)	1,716
Dues and Subscriptions	51,566
Fund Raising/Marketing	47,058
Human Resource Fees	196
Drug Testing	5,855
Less: Public Relations Expense	(47,058)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 75,640

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	15,883
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,883

**See instructions.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - $7,132**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,663** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **77,200**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **35,685** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,061**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Frost, Ruttenberg, and Rothblatt, P.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will forward upon completion**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw